INDIVIDUAL APPLICATION/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

EMPLOYER (GROUP) NAME			**GROUP NO.**
EMPLOYEE LAST NAME	**FIRST**	**MI**	**DATE OF BIRTH**
STREET ADDRESS	**CITY**	**STATE**	**ZIP**
SOCIAL SECURITY NUMBER __ __	**GENDER** ☐ **Male** ☐ **Female**	**CONTRACT TYPE REQUESTED** ☐ **Single** ☐ **Employee/Spouse** ☐ **Family** ☐ **Limited Family (Parent/Child or Parent/Children)**	
EFFECTIVE DATE OF COVERAGE *OR* CHANGE		**DATE OF HIRE**	

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ **EMPLOYEE** ☐ **SPOUSE** ☐ **DEPENDENT(S)**

TYPE OF CHANGE: ☐ **NEW ENROLLMENT** ☐ **CHANGE OF ADDRESS** ☐ **NAME CHANGE** ☐ **REINSTATEMENT**

☐ **ISSUE CARD** ☐ **CANCEL COVERAGE** ☐ **NAME CHANGE, FORMERLY** _____

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** _____ DATE: _____

EMPLOYER SIGNATURE: **X** _____ DATE: _____

NATIONAL VISION ADMINISTRATORS, LLC.
1200 Route 46 West
Clifton, NJ 07013

www.e-nva.com

Toll Free: (800) 672-7723